ASSESSMENT AND TREATMENT PLANNING

A GUIDE FOR CLINICIANS

Cynthia Banfield-Weir
L.I.C.S.W. B.C.D
Community Health Care
Chicopee, MA

DISADVANTAGES OF TREATMENT PLANNING

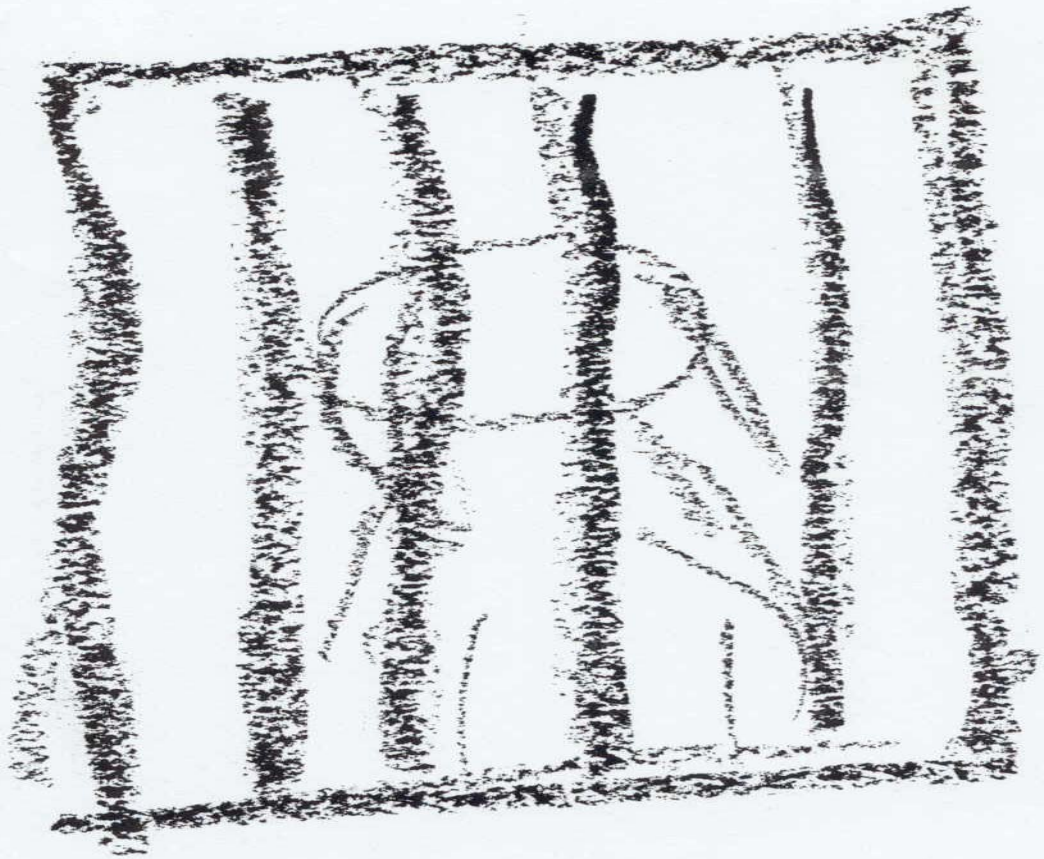
- There is no common language to use in writing these documents.
- Treatment planning puts focus on the paperwork rather than the patient.
- Treatment planning takes away from work with the patient.
- If treatment plans are written correctly, it may be difficult for the clinician to keep up with the changes in treatment, which are processed as the treatment progresses. These can be time consuming to write.
- Everything must be measurable which makes the plans seem overly behavioral and trivial.

ADVANTAGES

- Having the ability to do plans in a way that is acceptable to accreditation and third party funding ensures that the clinician will be paid.
- Communicates the treatment to all members of the treatment team.
- Ensures that the clinician think analytically and critically about the interventions that are best for the patient at a given level of treatment.
- Assists in keeping the clinician alert to modifying the treatment when it is ineffective.
- Helps patients be informed as to the process of change expected in their treatment.
- Gives clinicians an opportunity to show that they know what they are doing.

THE PURPOSE OF THE TREATMENT PLAN

- Communicate the purpose of a given treatment to all parties involved in the process; including patients, counselors, referral sources, 3rd parties, and accrediting bodies
- Provides a measure for a patient's progress in treatment.
- Defines and measures interventions in patient care.
- Assures that problems identified at assessment are not forgotten.



ASSESSMENT

THE BASIS FOR TREATMENT PLANS.

A plan is only as good as the assessment.

ASSESSMENT

Purpose:

- To develop a biopsycosocial evaluation of the person
- To discover the individual differences in person’s with the same syndrome
- To assess the etiology of a person’s syndrome

ELEMENTS OF THE ASSESSMENT

RELEVANT FAMILY HISTORY

- Describe growing up in this family
- Number of children
- Parent’s work
- Divorce
- Separation
- Substance abuse
- Psychiatric History

HISTORY OF VIOLENCE

- Physical Abuse
- Sexual Abuse
- History of Rape
- Self-Mutilation
- Combat Experience
- Other- Battering, Harm to Animals, A&B, B&E

EMPLOYMENT HISTORY

- What kind of work
- Longest continuous Employment
- Typical length of stay
- Reasons for leaving
- Present Employer

EDUCATION

- Highest Grade Completed
- School Performance
- Participation in extra-curricular activities
- Peer Relationships
- School performance

CURRENT LIFE SITUATION

- Present living arrangements
- Others in living environment
- Current Social Supports
- Sexual orientation

MEDICAL HISTORY

- Chronic medical conditions
- Surgeries
- Hospitalizations
- Physical Disabilities

RELATED MEDICAL HISTORY

- Current Medications
- Primary Care Physician
- Allergies

PSYCHIATRIC HISTORY

- Treatment for psychiatric illness
- Use of medications
- In-Patient Hospitalization

LEGAL HISTORY

- Probation
- Parole
- Jail time served
- Court Cases Pending

SPIRITUAL BELIEFS

- This is a dimension of the person
- The need to experience the divine
- The desire to find meaning in the universe that transcends existence
- Participates in organized religion
- Is part of a less formal system

Substance Abuse Assessment

- There is evidence of marked tolerance: a need for marked increased amounts of AODs to achieve intoxication or a desired effect, or markedly diminished effect with continued use of the same amount.
- Evidence of characteristic withdrawal symptoms.
- AODs are often taken in larger amounts or over a longer period of time than the person intended.
- The person has a persistent desire or has made one or more unsuccessful efforts to cut down or control AOD use.
- The person spends a great deal of time in activities necessary to obtain, consume, or recover from AOD effects.
- Important social, occupational, or recreational activities are given up or reduced because of AOD use.
- AOD use continues despite knowledge of having a persistent or recurrent social, psychological, or physical problem that is caused or exacerbated by AOD use.

MENTAL STATUS EXAM

- ASK

A Series of questions to assess the presence of psychiatric symptoms


Too much stuff in my Head
CONFUSSED!

APPERANCE AND BEHAVIOR

- Describe
  - Age
  - Dress
  - Facial Expression
  - Motor behavior
  - Attitude toward the interviewer

SPEECH

- Volume
- Rate
- Spontaneity
- Impairments
- Word finding problems

MOOD AND AFFECT

- Mood is the patients description of their feeling
- Affect is the clinician’s observation of patient’s mood.

PROBLEMS WITH EATING AND SLEEPING

- Weight loss
- Appetite
- Sleep patterns- changes

STREAM OF THOUGHT

- Rate of speech
- Tangential
- Coherent
- Circumstantial
- Loose Associations
- Flight of Ideas

WORRY/ PREOCCUPATIONS

- Do you worry that you might do or say something that would embarrass you in front of other? (eating, public speaking, using restroom)
- Some people have fears of being in certain situations i.e. Being away from home, standing in lines, driving in a car, or being home alone.

OBSESSIONS

- Thought or impulses that don’t make sense. For example thoughts that you might hurt someone you love even thought you don’t want to or become contaminated by germs or dirt.
- How often does this happen?
- How do you feel when you have these images?
- What do you do to try to get rid of them?

COMPULSIONS

- Are you ever bothered by having to do something over and over that you can’t resist even when you try?
- Checking, washing, and counting
- Do you have any rituals that you always that you always have to do in a particular order and if the order is wrong you have to start over?

PHOBIAS

- Some people have very strong fears of certain objects or situations. Do any of these make you nervous?
  - Snakes, Spiders, heights, flying, blood, water storms, etc.
- Do you think you are more afraid than you should be?
- What problems do you have in your life as a result of these fears?

DELUSIONS

- Delusions are usually NOT bizarre but rather involve situations that could happen in normal life such as infidelity, being followed, or illness.
- Is anybody against you, following you? Or giving you a hard time?
- Have you noticed special messages in the paper, radio, or TV for you?

DELUSIONS

- Do you think that you have done something terrible and deserve to be punished?
- Do you think that you may become famous or do great thing? Do you have thoughts like this and what are they?

HALLUCINATIONS

- Do you hear, see, taste things that other people don't seem to notice?
- Do you ever get the feeling that you are controlled by someone else?
- Do you think people can hear your thoughts?
- Do you feel there are thoughts in your head that were put there by someone else?

ORIENTATION AND CONCENTRATION

- To, place person and time
- Attention skills/ Distractibility

MEMORY

- Recent memory for 3 objects after 5 minutes
- Resent memory- name the past 4 presidents

JUDGEMENT

- Awareness of current problems and probable future in one year.

SUICIDAL IDEATION

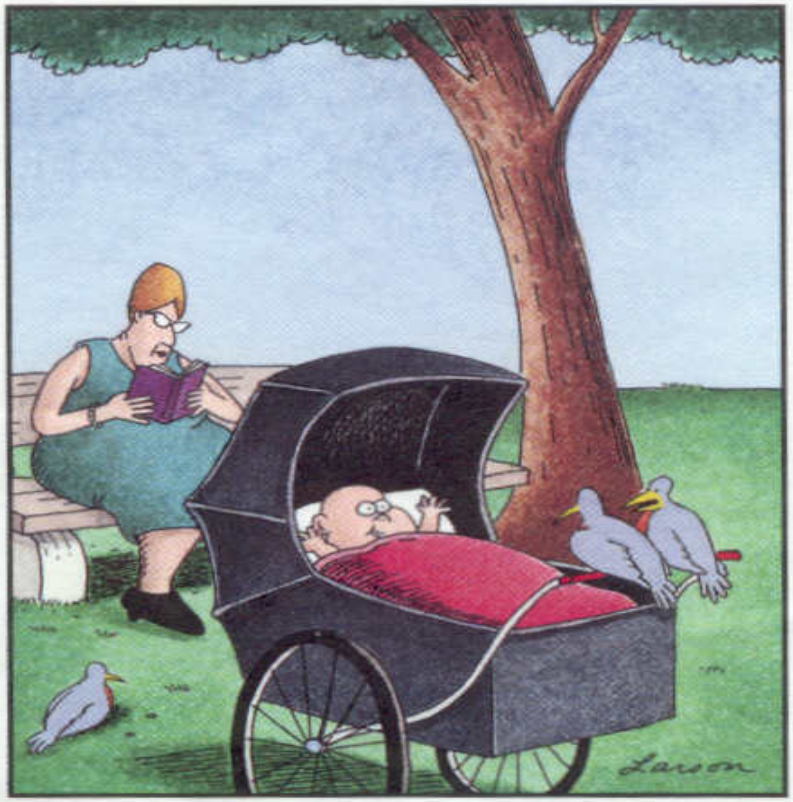
- Previous attempts
- Wishes to harm self
- Plan
- Intent to carry out

HOMICIDAL IDEATION

- Previous Thoughts an behaviors
- Wishes to harm other
  (general/specific)
- Plan
- Intent

FORMULATION

- Clinical summary that integrates and interprets from a broader perspective assessment data
- Identifies central themes
- Discusses the interrelationships between sets of findings
- Articulates clinical judgments regarding positive and negative factors likely to effect TX.
- Recommends treatments, needed assessments and referrals
- Discusses the anticipated level of care, expected focus and recommendations.



"It's still hungry ... and I've been stuffing worms into it all day."

The Far Side®

November

1946

Dr. Benjamin Spock publishes *The Common Sense Book of Baby and Child Care.* (Oh, just smack the kid.)

Tuesday 28

PROBLEM LIST

- Mental Health
- Substance Abuse
- Medical
- Psychosocial
- Vocational
- Marital
- Legal
- Self Care

STEPS TO WRITING A TREATMENT PLAN

PROBLEM STATEMENT

Problems should be written as negative statements and so as to indicate action to be taken

- Problems must be individualized to each patient. All patients have opioid addiction. How is this a problem for this person?
- What words does the patient use to describe their problem?

WHERE IS THE EVIDENCE?

- Problem statements should include evidence of the problem.
- How do we know this is a problem?
- Problem statements assists to individualize
- Problem statements may include patients own words to describe the problem.

GOALS: RESTATED PROBLEM IN POSITVIE TERMS

- Example: Problem- The patient does not have any social supports
- Goal- The patient will gain social supports

- Example: Problem- The patient wets the bed.
- Goal- The patient will be free from bed wetting

LONG AND SHORT TERM GOALS

- Goal is also an behavioral outcome statement.
- If someone achieved a particular goal it could be measured.
- Long term goal is the best eventual resolution
- Short term goals are behavioral steps along the continuum the patient must take to meet the long term goal.

THE OBJECTIVES

- What will the patient do that indicates that the goal is attained?
- How would one differentiate between the person who achieves the goal and one who does not?
- The objective must be measurable , specific and time limited.
- Objectives are written as “The patient will…”
- The objective must be realistic as something that the patient really could achieve.
- Each objective should have only one item.

THE INTERVENTION

- What will the clinician do to bring about change?
- What is the clinician's theory for bringing about change?
  - Cognitive behavioral
  - Motivational interviewing
- At least one intervention must be written for each objective.
- Each intervention must be measurable and specific.

DATES OF THE EXPECTED OUTCOME FOR EACH GOAL ARE MANNDATORY ON THE TREATMENT PLAN.

- How long does the clinician and the MDTC team estimate that the achievement of the short term goal will take?

THE PLAN SHOULD:

- Identify the person's need for another level of care.
- Ensure the continuity of care.
- Include the input and participation of:
  - The person served.
  - The family or legally authorized representative, when appropriate.
  - Appropriate personnel.
  - The referral source, as appropriate.

THE TREATMENT PLAN IS A ROADMAP OF TREATMENT

- Treatment previously given to the patient is recorded on old treatment plans and supported by progress notes.
- In the case of new problems add them to the treatment plan.
- It is a changing document.

COGNITIVE BEHAVIORAL TREATMENT PLAN

- Educate the person served about cognitive behavioral therapy (situation, feeling, automatic thought, hot thought, behavior, evaluation of the hot thought, development of alternative thought)
- Educate the person served about the role he/she will play in the treatment.

COGNITIVE BEHAVIORAL TREATMENT PLAN (CONT.)

- Develop with the person served a rating scale for emotions (sad, anxious, angry, ashamed, disappointed, jealous, guilty, hurt, and suspicious.)
- Use automatic thought adaptive coping cards, role play, diary cards, logs, consider advantages and disadvantages, moving ahead in time, conduct behavioral experiments, using other people's beliefs to modify thoughts etc.
- Identify a baseline measurement of the problem (Beck's Depression Inventory)

MOTIVATIONAL INTERVIEWING PRECONTEMPLATION

- Relies on clinical interventions that move patient through identifies stages of change.
- Precontemplation- raise doubts and concerns about problem.
- Providing factual information
- Exploring the pros and cons of having the problem
- Examining discrepancies between patient and other perception of problem behavior.

MOTAVATIONAL INTERVIEWING CONTEMPLATION

- Normalize ambivalence
- Examine patients personal values
- Elicit self motivation statements and summarize them
- Change extrinsic to intrinsic motivation
- Elicit self motivation statements of intent and commitment from the client.

"Randy's goin' down!"

The Far Side® November

1934

The Ford Gum and Vending Co. begins manufacturing penny gum machines.

Wednesday 8

THE ROLE OF THE CLINICIAN

- Educate the patient as to the expectations of the patient and clinician.
- Develop the treatment plan WITH the patient.
- Review with the patient his/ her progress in achieving the treatment plan goals.
- Negotiate any changes in the treatment plan with the patient.
- The patient should know what is on the plan.

PROGRESS NOTES

- Follows a consistent format throughout the organization
- Refers to patient response to treatment plan objectives.
- Describes treatment interventions used toward goal achievement.
- Deals only with material listed on the treatment plan.

THE ROLE OF THE SUPERVISOR

- Determine whether the assessment, formulation, problems, goals, objectives, and interventions are appropriate to the diagnosis.
- Modify treatment interventions and goals.
- Order additional diagnostic and treatment services as needed.
- Match the treatment described in progress statements with the written treatment plan.

IF AT FIRST YOU DON'T SUCCEED TRY AND TRY AGAIN!

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cynthiabw@csacmethadone.com